Cavendish Coalition
Staffing the health and social care system after Brexit

Cavendish Coalition working paper on future immigration policy options – June 2018: supporting the delivery of high quality social and health care services

The Cavendish Coalition

The Cavendish Coalition brings together 36 social and health care employer and staff representative organisations working across the UK.

The aim of the Coalition, following the UK's decision to leave the European Union (EU), is to make certain that the social and health care system can continue to attract and retain the staff it needs – domestically, from across the EU, and globally.

Purpose and status of this working paper

A key issue that will impact whether the social and health care system can continue to attract and retain the staff it needs is future immigration policy.

While there is much uncertainty, it seems relatively clear that, once the UK leaves the EU and a proposed transition period is completed, the status quo of freedom of movement for people from the European Economic Area (EEA) will end.

The question of what immigration policy will then apply to people from the EU, and indeed the rest of the world, who wish to come to the UK, including to work in social and health care, is of great significance and core to the work of the Coalition.

The Coalition policy group have therefore developed this working paper for the purpose of exploring the implications for the social and health care system of the main future immigration policy options of which we are aware from public debate and reports produced by others. By developing an understanding of the implications of the various options we want to be well prepared to constructively contribute to public discussion and inform decisions and work by government and the Migration Advisory Committee to shape a future immigration system.

This is a working paper. As such it represents our current thinking as of June 2018 in a context of much uncertainty and is subject to change in light of external developments and further discussions within the Coalition. The thinking set out in this paper does not represent our final position and we are not advocating for any particular way forward at this point. We also acknowledge that there may need to be particular arrangements following the UK's exit from the EU for migration across the Northern Ireland/Irish Republic border; the Scottish government has raised the possibility of it having greater flexibility over immigration policy in respect of Scotland and the Welsh government has also raised their preference to remain in the customs union and single market to facilitate freedom of movement.

This paper explores the underpinning principles for a new immigration system, including:

- a high-level position on the overall aspirations from an immigration system for social and health care,
- the unique factors relating to the social and health care workforce we want to ensure are appropriately recognised in decision making about future immigration policy, and
- an overview of the benefits and challenges for social and health care of the main options for a future immigration system.

Social and health care workforce supply challenges

At present, the sustainability of some social and health care services is a major problem: insufficient staff, including nurses, social workers, doctors, dentists and physiotherapists are being trained and retained. This puts an unacceptable pressure on all social and health care staff and threatens the delivery of essential services. While the workforce in the sector has grown, it has still not kept up with a growth in demand. There are currently around 100,000 vacancies across the NHS[1] in England alone and in adult social care the vacancy rate was reported 6.6% in 2016-17, this equates to approximately 89,000 unfilled posts[2].

The sector is caring for and treating a growing and ageing population that grew by 2.1 million (4%) over the last five years. The number of people with long-term conditions has grown sharply, as have advances in medical care and treatment – meaning people are living for longer. Future projected demand for social and health care services means that the NHS will need to grow by 190,000 clinical posts by 2027 to meet this demand[3] and between 350,000 – 700,000 new jobs in social care will be required by 2030[4].

NHS employees also comprise an essential part of the UK's international strength in the life sciences industry. Functioning at the interface between health services, academia and industry there are many NHS staff ranging across the full breadth of professional disciplines who are required to ensure future success for the UK economy and ongoing patient benefit from access to the outputs of research. The Medical Schools Council have highlighted the structural issues concerning the long-term pipeline of clinical academics in the UK.[5] Immigration policy is a fundamental component of the joined-up workforce planning that is required to secure a sustainable clinical academic workforce. The significance of this agenda is amplified when considering the workforce employed in university and the wider life sciences industry.

Action has and is being taken by the sector to address the current domestic supply shortfalls, but it takes time to develop a new and additional pipeline of talent. In England, a national workforce strategy for both the NHS and adult social care is in development – drawing together the different elements of activity that are already underway to help increase workforce supply and improve the employment offer as well as set the tone for the longer term. This work is essential and has the full

[1] NHS Improvement, Performance of the NHS provider sector for the month ended 31 December 2017, February 2018
[2] National Audit Office, The adult social care workforce in England, February 2018
[3] Public Health England, Facing the Facts, Shaping the Future - A draft health and care workforce strategy for England to 2027, December 2017
[4] Skills for Care, National Minimum Data Set for Social Care (NMDS-SC), 2016-17 workforce estimates
[5] https://www.medschools.ac.uk/media/2026/medical-clinical-academic-staffing-levels-2017.pdf

support of employers, representative bodies and trades unions. It will take time to see a significant impact on the size overall workforce and if the labour market for skills and labour becomes increasingly competitive, it will be important for both social care and health organisations to compete on our offer – including pay and wider reward offering. As an example, on the timeline to train: the increase in medical school places from 2018/19 will result in additional doctors becoming consultants in around 2030-32.

As part of positioning social care and health as an employer of choice, the recent work to reform pay in the NHS in England is welcomed and is an important step forward. As a Coalition seeking to ensure the sustainability of services across the UK in social care and health, we all know the importance of ensuring that funding is available to enable social care to improve their pay offer if they are to be competitive within the social care and health sector and the wider economy.

There is also significant support for national recruitment campaign. Whilst primarily focused on attracting new talent into social care and health, the visible investment in promoting and valuing the work of the whole sector could have a positive impact on the current workforce.

Social and health care employers are looking at ways in which to make best use of all available staff and reconsidering the way in which services are provided. The sustainability and transformation plans in England look at the social and health care needs of local populations and at how integrated care can best be designed to meet future needs in a realistic and sustainable manner.

However, EEA nationals are providing vital contribution and helping to fill the persistent shortages in the UK workforce in many parts of the sector. There are currently approximately 165,000 EEA nationals known to be working in social care and public and independent health organisations across England alone, with EEA staff also working in services in Northern Ireland, Wales and Scotland:

- 95,000 in adult social care in England[6]
- 62,000 in the NHS in England[7]
- 8000 in independent health organisations.

Despite opportunities for increasing our domestic workforce supply, social and health care services will continue to depend on workers from outside of the UK during the period of negotiations on the UK's withdrawal from the EU and in the years after the UK leaves. We know this because there are vacancies and gaps in skills across the sector now.

This was recognised in the published evidence from Department of Health (now Department for Health and Social Care) to the Migration Advisory Committee call for evidence:

'the department of health said that if the NHS were no longer able to recruit EEA doctors, nurses and other health professionals it was estimated that, after five years, there would be around 6,000 fewer doctors and 12,000 fewer EEA nurses in the UK. The Department told us that extra training places and reduced attrition rates could help reduce this shortfall, but such interventions

[6] National Audit Office, The adult social care workforce in England, February 2018
[7] House of Commons Library, NHS staff from overseas: statistics, February 2018

were likely to be less effective given the action that is already underway and would be insufficient to fully bridge the gap.' [8]
(paragraph 73)

If we consider this alongside already low levels of unemployment in some regions, the length of training time and a forecasted increase in demand for social and health care services, the workforce supply gaps look set to worsen.

Unique factors relating to the social and health care workforce

There are a range of unique and interdepending factors relating to the social and health care workforce that mean as a sector, it is not feasible to meet current staffing needs through either additional domestic recruitment or training activity alone in the short to medium term. Due to the criteria and rules that make up the current immigration process for non-EEA nationals, meeting staffing needs for the sector through non-EEA recruitment is similarly unfeasible from our perspective.

Specifically, there are workforce challenges experienced by both social and health care employers that we want to make sure are appropriately recognised in decision making about future immigration policy:

- Social and health care services are present in every community, in every part of the UK and play a vital role in the health and welfare of communities
- Demand on both social and health care services is rising and this trend looks set to continue
- It takes time to educate and train the social and health care workforce, and therefore boost domestic supply of staff to meet this rising demand for services.
- Continuity of care requires a stable workforce to build relationships with the people they support. Insufficient or gaps in services also increase the burden on carers and the potential to add further demand on social and health care services[9].

The social and health care sector is an interconnecting and complex system which requires all parts to be functioning effectively to ensure it can work. There are other factors, more specifically impacting on the social care workforce, for instance care for working age adults with a learning disability is almost entirely funded from public money, and commissioned by Local Authorities and Clinical Commissioning Groups. Consequently, fees are set by public bodies and given the funding pressures that are being experienced by Local Authorities, many frontline staff are paid at or just above national living wage/national minimum wage levels, this inevitably brings difficulties to recruiting and retaining the workforce.

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[8] Migration Advisory Committee interim report: (paragraph 73) https://www.gov.uk/government/publications/health-call-for-evidence-responses March 2018
[9] Carers UK, State of Caring 2017, https://www.carersuk.org/for-professionals/policy/policy-library/state-of-caring-report-2017, July 2017.

We cannot afford for the UK's withdrawal from the EU to compound the workforce challenges already faced by employers across the sector. We need security and certainty for our current EEA nationals and a sensible longer-term plan to ensure the security of a workforce for the future. Continued uncertainty risks the stability of some patient care and social care provision, even in the relatively short time span since the referendum in June 2016, the data indicates that fewer EEA nationals are joining the NHS in England, and more are leaving than immediately before the referendum.

> *According to NHS Digital data, the number of EEA joiners to the NHS in England decreased by 17.6% between April and June 2016 and the same period of 2017, equivalent to 700 fewer joiners.*
>
> *Between April and June 2017, around 3,300 workers that had reported a non-British EEA nationality left the NHS in England, about 500 more leavers than the same period of 2016[10].*

The future immigration system

Leaving the EU provides the UK with an opportunity to re-set and review our approach to immigration and the systems and processes which underpin it. This is an opportunity for the UK to establish new systems for managing immigration which properly recognise those circumstances where our sector may need to complement domestic supply with international workers to maintain patient safety and provide continuity of care.

We are clear that any new system will need to take account of the value and contribution the social and health care sector provides to the UK economy and its population, with public service value used as a key assessment of 'skill'. This will enable recognition of the range of roles we might need to recruit to including world class medical researchers, care workers and domiciliary workers, paramedics, nurses, pharmacists, doctors and dentists.

Aims and principles

We have looked firstly at the overall aspirations of migration policy for the UK and then the specific aims and priorities for the social and health care sector.

Immigration policy must support the delivery of growth of the UK economy by ensuring the UK is positioned as a global leader in healthcare, industry, science, technology, research and education. While at the same time facilitating the reciprocity of opportunity with our global partners for British citizens. It is our view that as a broad social and health care sector, we have a key role in achieving this ambition through:

[10] National Institute of Economic and Social Research, The health and social care workforce in the UK: The role of EEA nationals, October 2017.

- Supporting the population to stay healthy, be fit for work, remain independent and stay in their own homes for as long as is possible.
- Supporting individuals with caring responsibilities to remain in employment.
- Attracting inward investment into academic health research and specialised clinical practice.
- Working with government to maximise our offer and expertise to the overseas market.
- Continuing to lead the way on the World Health Organisation Code of Practice on ethical international recruitment, and deliver on the UK commitments to ethical recruitment and improving global health.

It is vital for our sector that immigration policy supports the delivery of high quality public services and helps the UK social and health care services to remain world leading. We need future immigration policy that:

a) Supports a strategy and plan to grow and develop our domestic supply of social and health care staff.
b) Maintains the ability of the sector to recruit quality and skilled staff from abroad when domestic supply is not available.
c) Recognises the value and contribution of the social and health care sector to the UK population, with public service value used as a key assessment of 'skill'.
d) Enables the sector to attract high calibre professionals in clinical practice, research and education, and infrastructure.
e) Provides opportunities for overseas nationals to learn and gain knowledge in the UK health system to support the improvement of health and healthcare systems abroad.

We set out six key principles which we believe should underpin immigration policy and the systems and processes it creates to ensure it is effective in the delivery of the aspirations:

1. **Responsive**
   Immigration policy must be closely co-ordinated with labour market policy and wider industrial strategy to ensure that the system works for the economic interests of the UK and is agile to meet future labour needs.

2. **Easy to understand**
   Immigration policy needs to set out clear and fair rules, underpinned by effective management, enforcement and control.

3. **Transparent**
   Immigration policy must be underpinned by clearly understood principles and decision-making must be informed by trusted evidence and open and honest debate.

4. **Predictable**
   Immigration process must be predictable and consistent so there is certainty for employers and individuals.

5. **Accessible**
   Immigration policy must be simple for individuals to navigate, employers to use and government infrastructure to oversee.

6. **Affordable**
   Immigration policy must avoid expensive burdens on employers, individuals and the government.

Immigration in the future and a skilled workforce

As a coalition, we have been very clear that the contribution of migration is about bringing much needed skills and talent to the UK in areas where our sector may need to complement domestic workforce supply, not replace it.

We are clear that public service value must be used as a key assessment of 'skill' in order to recognise the range of roles we might need to recruit to, including care workers and domiciliary workers, paramedics and nurses, doctors, dentists and pharmacists and world class medical researchers.

The definition of what constitutes highly skilled, less skilled, low skilled or unskilled is not always clear within the immigration debate nor with the public. However, a number of different opinion surveys have shown that the public do not view all types of immigration in the same way.

Research conducted by British Future and HOPE not hate[11] through 30 citizen panels reinforces that the public would like to reduce migration overall, but there were exceptions to this. Rather than taking a 'one size' fits all approach, most people made distinctions between different types of immigration, some they would like to reduce, others they would like to keep at current levels or even increase.

When asked what approach to immigration Britain should take after it leaves the EU, the overwhelming majority of participants were happy for the levels of high-skilled migration from the EU to be increased or to remain the same. Participants want tighter controls on the numbers of low-skilled or seasonal workers.

When asked what kind of jobs people classify as 'low skilled', most participants believe these are jobs for which no qualifications are required, such as cleaning, fruit picking or bar work. Jobs such as nursing and care work are not classified by the public as low skilled work. This is an important observation to make because it does not fully chime with the definition of 'high' and 'low' skilled work in the current immigration context. As a graduate profession, registered nurses are classified as "skilled" under the UK's immigration system. But for instance, senior care workers and nursing assistants are occupations which are currently ineligible for sponsorship in Tier 2 (general) due to the skill level[12].

[11] British Future and HOPE not hate, National Conversation on Immigration An interim report to the Home Affairs Committee, 2018
[12] Home Office, Immigration Rules Appendix J: codes of practice for skilled work, updated January 2018

Participants saw immigration as being positive when migrants bring skills and undertake important work.

The recommendation from the Home Affairs Select Committee in their report 'Immigration policy: basis for building consensus'[13] is for an immigration system to treat different skills differently. The report concludes that there is public support for the continued arrival of high-skilled (not just highly paid) workers who are needed in the economy. Immigration rules should allow UK businesses and organisations easily to attract top talent, with restrictions and controls focused more on low-skilled migration.

For social and health care organisations it will be critical to find the right balance of Government 'controls' particularly as many occupations we employ are currently defined as low or lower skilled.

Possible scenarios

In this section we have explored all options, even those that do not align with current government policy or narrative. As a coalition we believe this important to do, to enable a rounded discussion about the benefits and challenges of each option.

We have identified four possible scenarios that the UK could adopt towards immigration in the future. Each scenario has benefits and challenges for the social and health care sector:

1. **The current immigration system for people from the rest of the world is extended to include people from the EEA.** This would be the most straightforward option for the government and allow the use of the existing infrastructure, however this scenario could limit the government's options for striking a more preferential deal with the EU. The social and health care sector would also need to secure significant changes to the current system to ensure it works for the sector, eliminating some of the barriers for example, the introduction of the immigration skills charge, the exclusion of key professions from the shortage occupation list and the fundamental mechanism of using salary as the single metric for determining skill, priority and value places the sector at a disadvantage.

2. **A new immigration system is introduced to include both people from the rest of the world and people from the EEA.** This is probably the best-case scenario for the sector as it would provide an opportunity to develop a system which better aligns to our aims for a new system. It would also provide an opportunity to re-set how immigration is managed to ensure a fair and transparent system is put in place for everyone. This scenario could limit the government's options for striking a more preferential deal with the EU. It would involve investment from the government and it is difficult to imagine that the system would be ready for when the UK leaves the EU so transitional arrangements would need to be put in place

[13] House of Commons Home Affairs Committee, Immigration policy: basis for building consensus, second report of session 2017-19, January 2018.

3. **The current immigration system for people from the rest of the world is retained, a separate and new immigration system is introduced for people from the EEA.** This is potentially a better option for the EEA workforce as it could be designed to preserve some freedom of movement on a more permanent basis. However, it would not resolve the barriers in the current system for non-EEA recruitment unless we could secure some changes. Maintaining two systems would mean however, continuing differential treatment of individuals based on nationality.

4. **A new immigration system for people from the rest of the world is introduced, and a separate and new immigration system for people from the EEA.** It's possible this approach could result in two systems that work well, however this is the most complex approach for the government to take and if developing a new system, the preference would be for one system that works for EEA and non-EEA migration. As with scenario three, maintaining two systems would mean continuing differential treatment of individuals based on nationality.

Potential EEA immigration systems

We summarise the options and implications facing the government of the potential models for future EEA migration.

Option 1: Retain free movement
This option would retain the current arrangements for EEA nationals to travel and reside in the UK without restriction.

Benefits:

- Maintains the ability for the sector to complement domestic supply with EEA workers when required.
- Facilitates the long-term investment of specialised skills and talent.
- Enforcement burden on employers is light.
- Likely to attract skilled workers to the country, including those without a job offer.
- Certainty throughout the process for individual and employer no cap on numbers.
- Low administrative burden on individuals, employers and Government.

Challenges:

- No central control over numbers of EEA migrants entering the UK.
- Supply (not demand) led.

Scenario
The number of EEA nurses working in the UK has been rising over the last ten years,[14] *5% of nurses currently on the Nursing and Midwifery Council (NMC) register trained within the EEA and 10% trained outside the EEA - this equals more than 33,000 EEA*

[14] Royal College of Nursing, UK nursing labour market review 2015, https://www.rcn.org.uk/professional-development/publications/pub-005348, October 2015.

trained nurses[15]. Despite their vital contribution and the UK's proactive recruitment, EEA/international nurses are not a substitute for a sustainable domestic supply - as evidenced by the continued existence of over 40,000 nursing vacancies in the NHS in England[16], a 4.1% vacancy rate in Scotland[17] and an estimated NHS vacancy rate in Northern Ireland of 6.9%[18].

It must be recognised that a change to the immigration policy restricting recruitment of EEA nationals, however minor, will compound the workforce supply challenges already faced by employers across the sector.

Option 2: Entry to UK with a job offer or authority to seek employment

This option could be a modified version of free movement of people with some additional requirements. These could include strengthening the resident labour market test and requiring employers to demonstrate domestic recruitment and retention efforts

Benefits:

- Efficient and responsive time to hire process.
- Demand (not supply) led - if job offer only.
- Parity across all social care and health employers.
- Does not discriminate by qualification or academic level required: would support the necessary recruitment of skills and labour from care workers to doctors and dentists.
- Provides assurance that migrant labour is only used where no source of domestic labour is available.
- Would support the nature of other EU collaborative work.
- Possible to track numbers of EEA migrant numbers.
- Light tough administration for individual, employer and government

Challenges:

- There is no central control over numbers of EEA migrants entering the UK.
- Enforcement could be difficult i.e. if individual leaves employment, would they be required to leave the UK? How would that be enforced?
- Extending resident labour market test to EEA nationals could increase administrative burden for employers.

Scenario

Doctors from the EEA and across the world play a crucial role in the delivery of care. Without them the current significant rota gaps would be further exaggerated leaving service sustainability increasingly vulnerable. It is estimated that between 7-10 percent of doctors working in the NHS and 6.5 percent of the UK medical

[15] Nursing and Midwifery Council (NMC) freedom of information request, June 2016.
[16] Royal College of Nursing, Safe and Effective Staffing: the Real Picture, *May 2017.*
[17] Information Services Division Scotland, NHS Scotland Workforce Information at December 2017, March 2018
[18] Department of Health Northern Ireland, Northern Ireland health and social care workforce census March 2017, August 2017.

workforce received their medical qualifications in other EU countries[19].

Research between 2016-17 shows that nearly half of advertised substantive consultant posts were not appointed to. This is likely the result of awarded certificates of completion of training (CCTs) being much lower than advertised posts[20] .

We need a future immigration system that maintains the ability of the sector to recruit skilled staff from abroad when domestic supply is not available.

Option 3: Work-permit system (sectoral allocation)
This option would mean each industry sector advocates for its own work-permit system and associated allocation.

Benefits

- Current UK system does not differentiate by sector but UK government does have some experience of operating this approach in the past.
- Sectoral allocation would remove the element of competition with other industry sectors.
- Additional sectoral specificity could support our sector's need for 'low-skilled' workers from outside the UK. For example, this could enable the recruitment of direct care workers into social care as well as health professionals.
- Control inward migration flows via an allocation responsive to need of – employer /population need.
- Gives clarity to the wider public on the role EEA nationals are playing in the economy.

Challenges

- Adopting an allocation system could imply there would need to be a limit/cap on numbers. In this scenario, it would mean developing a priority ordering system. Currently there is no formula for recognising 'value' and the contribution of public services to the wider UK economy and society. Salary is the main factor used to determine value.
- The health sector has experience of how an arbitrary cap on numbers can work in practice, when the demand for skills and talent exceeds the cap. The allocation would need to be sufficiently flexible to respond to need and changing needs. Adopting the approach used for tier 2 'unrestricted certificates' would remove the need for a priority ordering formula but it would add a layer of administration for employer and Government to manage and resource, in comparison to the current position of free movement.
- Adds complexity to the administration and enforcement of the immigration regime.
- There could be significant additional costs if sponsorship, visa and related fees are required. These would have to be paid by employers as well needing to allocate resource to manage the new and additional processes.

[19] General Medical Council, registration statistics, http://www.gmc-uk.org/doctors/register/search_stats.asp, July 2017.
[20] Royal College of Physicians, Census of consultant physicians and higher specialty trainees in the UK 2016-17, June 2017

- Requires accurate data on current and required workforce across social and health care in UK, to function effectively.

Scenario

Although it remains highly competitive, fewer people are choosing medicine as a career with many more choosing to leave the health service at a time when they are needed most. The number of people applying to medical schools has decreased by more than 13% since 2013 and nearly three quarters of all medical specialties faced under-recruitment in 2016. Also, last year, just 50.4% of F2 doctors reported that they would progress directly into specialty training following completion of their Foundation Programme training. This is leading to rota gaps and raises concerns about the ability of the NHS to adequately staff services down the line. Many specialties face acute shortages including general practice, emergency medicine, paediatrics, occupational medicine, radiology and psychiatry.

Option 4: Work-permit system (Regional allocation for each UK administration)
This option would allow distinct areas of the country or across the constituent parts of the UK to have greater control of immigration based on their needs.

Benefits

- Increased regional autonomy over immigration policy to address regional economic need and demographic issues.
- Aligns with devolution model and local growth agenda.
- Allocation could be flexible and responsive to regional labour market.
- Support retention of skills in the region/country.
- A number of other countries (e.g. Australia and Canada) use region-based approaches so lessons can be learnt from their experience.
- Can flex demand based on need – demand (not supply) led.

Challenges

- Additional complexity to the administration and enforcement of the system – burden will sit with employers and require multiple layers of Government infrastructure.
- Regional need might be more difficult to identify due to available data.
- If prioritisation is based on salary or academic qualifications this would not work for social and health care employers.
- There'd be significant additional costs as the sponsorship, visa and related fees would have to be paid by employers.

Scenario

The nationality of NHS staff differs across regions in England. London and the Thames Valley report the largest proportion of EEA nationals in the NHS workforce. As at March 2017, the

proportion of EEA nationals working in London ranged between 11.2% and 11.9%, above the 5.6% figure for the whole country. In contrast, the North East of England has the lowest participation of EEA nationals with less than 2% of staff.

EEA nationals in the adult social care workforce are most prevalent in London and the South East, where they make up 13% and 11% of the workforce respectively, and EEA nationals are also overrepresented in the East of England and the South West. The smallest shares of EEA nationals in the adult social care workforce are found in the North of England, with shares of 2% in the North East, 3% in Yorkshire and the Humber and in the North West[21]*.*

An immigration system with increased regional autonomy could be more responsive to regional economic need and demographic issues.

Option 5: Work-permit system (linked to shortage occupation list)
This option would mean that visa allocations could be used for occupations identified as being in national shortage (UK wide, plus additional occupation lists e.g. Scotland, Wales).

Benefits

- Could ensure we are able to prioritise overseas recruitment by the occupations the sector has identified are shortage
- Prioritisation not based on salary or academic qualifications could work for social and health care employers.
- Demand (not supply) led – visas granted for occupations in national demand.

Challenges

- Questionable how the system would account for regional or local workforce shortages
- This option could need significant infrastructure to administer, review and deal with requests for inclusion to the list.
- Responsibility on employers to identify skills, numbers required and to demonstrate responsible workforce strategy – difficulties associated with achieving this status in the current system.
- This option would not work within the permanent limit on migration currently set for non-EEA nationals.
- Would limit opportunities for skilled and specialist recruitment into the UK from across the EEA if there was no other route into employment.
- There'd be significant additional costs as the sponsorship, visa and related fees would have to be paid by employers.

[21] National Institute of Economic and Social Research, The health and social care workforce in the UK: The role of EEA nationals, October 2017.

Scenario

Physiotherapy is not currently recognised as a national shortage occupation for non-EEA migration. It is one of many professions in the social and health care sector that is demonstrably in shortage, but could struggle to gain national shortage status within a work permit system linked to shortage occupations.

The gap between the demand for trained physiotherapists and the numbers trained and available, particularly in England, has led to a growing reliance on physiotherapists from overseas, including from the EEA[22]. Figures from the Health Care Professions Council shows that as of October 2016 there are 7088 (13.7%) physiotherapists registered to work in the UK who were trained outside of the UK, of which 3652 (7% of all HCPC registered physios) qualified in the EEA.

There is a current shortfall in physiotherapists, creating capacity issues now and storing up problems for the future as demand grows. Unless this system option was flexible enough to capture all the occupations the sector has identified are shortage, it would limit opportunities for recruitment of vital skills into the UK from the EEA if there was no other route into employment.

Option 6: Extend current system for non-EEA staff

This option would see EEA nationals treated in the same way as non-EEA nationals in the current immigration system.

Benefits

- This system is known to employers – easy to understand as a concept
- Infrastructure is already in place (although complex and burdensome)
- For Government: it enables the restriction of inward migration for employment by requiring employers to apply for a certificate to sponsor an individual into employment – of which there are 20,700 available per annum across all of industry.
- Requires employers to demonstrate how they have attempted to recruit from the resident labour market
- Option to introduce Tier 3 for low-paid, low-skilled migration which could be utilised by social care employers.
- Occupations are prioritised according to available data on shortage.
- EEA migrants and non-EEA migrants are treated equally.

Challenges

- Would not meet the workforce needs of social and health care without system reform
- Heavy administration processes and costly for employers and individuals

[22] The Health and Care Professions Council. FOI Disclosure Log; London, The Health and Care Professions Council; 2016. http://www.hcpc-uk.co.uk/aboutus/foi/disclosurelog/

- Complex and burdensome – leaving the EU provides an opportunity to design an immigration system that is enforceable and simpler for the individuals and organisations involved.
- Does not support the ambition for the UK to be a global magnet for talent.
- Minimum requirements in eligibility criteria include qualification level of degree and above, and except for a few exemptions, earn a minimum of £30,000 per annum. This does not work for social care and many roles in health care.
- Current priority system with limited number of visas disadvantages social and health care - priority scoring based on salary – no formula for recognising value public service brings to overall UK economy.
- The current system has a cap on certificates for tier 2 (the work based route). During 2015 and 2018 there were multiple occasions when the monthly limit was reached which led to disruption, additional cost, reduced productivity and impacts on patient care.
- Home Office capacity to process applications from EEA nationals as well as those from outside of the EEA[23].

Scenario

The social care workforce in 2016, according to the National Audit Office, had 6.6% of roles in adult social care vacant, this equates to approximately 89,000 vacancies at any one time. The vacancy rate between 2012/13 and 2015/16 had risen each year, from 5.5% in 2012-13 to 7.0% in 2015/16[24]. In short, there are already significant shortages in the sector, and no evidence that EEA nationals are displacing UK workers.

Extending the current system for non-EEA staff to EEA nationals would not meet the workforce needs of the sector without significant reform. For instance, the demand for social care staff is increasing, and as the bulk of social care is commissioned by Local Authorities and Clinical Commissioning Groups, the wages paid to staff are dictated by market places with only a small number of purchasers. For any new system to work for the sector, the "public value" of job roles must be taken into account.

[23] Home Affairs Select Committee, Home Office delivery of Brexit: immigration, February 2018
[24] National Audit Office, The adult social care workforce in England, February 2018